TABLE OF COMMENTERS

GOVERNOR'S OFFICE OF HEALTH POLICY & FINANCE

FIRST PUBLIC COMMENT PERIOD
DEADLINE FOR COMMENTS: JULY 9, 2003

CHAPTER 101
ESTABLISHMENT OF THE CAPITAL INVESTMENT FUND

1. David Winslow, Maine Hospital Association
2. Paul Gray, MaineHealth
3. Cathy Gavin, Maine Health Purchasing Collaborative
4. Katherine Pelletreau, Maine Association of Health Plans
5. Joe Ditre, Consumers for Affordable Health Care
6. Jay Houghton, Maine Peoples Alliance
7. Brenda Joly, Maine Center for Public Health
8. Sara Stalman, MD, Maine Peoples Alliance
9. Deb Cook, Maine Small Business Alliance
10. Wayne Myers, private citizen
11. David Brennerman, UnumProvident
12. Mary Henderson, Maine Equal Justice Partners
13. Pat Philbrook, Maine State Nurses Association
14. Kristine Ossenfort, Maine State Chamber of Commerce
15. Eileen Skinner, Mercy Hospital
16. Kevin Gildart, Bath Iron Works
17. Rick Erb, Maine Health Care Association

In addition:

18. Tony Marple, MaineGeneral, testified at the public hearing on the CIF convened by the Advisory Council on Health Systems Development

SUMMARY OF PUBLIC COMMENTS
JULY 9, 2003

GOVERNOR'S OFFICE OF HEALTH POLICY & FINANCE

CHAPTER 101
ESTABLISHMENT OF THE CAPITAL INVESTMENT FUND

The Governor's Office of Health Policy and Finance received both oral and written comments on our proposed rule, Chapter 101, setting out the process for establishing the Capital Investment Fund. The proposed rule was made public on June 9, 2003 and public comments were accepted until June 29, 2004. A total of 16 persons provided a range of comments on the proposed rule. In addition, one person provided testimony on the proposed rule at a hearing held by the Governor's Advisory Council for Health Systems Development. The comments of each of these parties are addressed in this document.

Comment: The formula used for calculating the actual amount of the Capital Investment Fund (CIF) lacks specificity and therefore does not allow the public to understand what the result of the formula will be. Data sources that will be relied on in the calculation should be explicitly cited. [Commenters 1, 5, 14, 15]

Response: We agree with the suggestion of these commenters and have specified in the rule the sources of data to be relied upon in determining the size of the CIF. These sources are listed below for the reader's convenience:

> In 3(A)(1), for determining the historical base for the calculation of the Fund, dollar figures are to be trended forward using the values for annual percentage growth in the cost of hospital care as published by the Office of the Actuary, Centers for Medicare and Medicaid Services, US Department of Health and Human Services, as published in a *Health Affairs* web exclusive, W4-79, 2004, which is available to the general public on the Internet.
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> The proportion of inpatient and outpatient revenue to total hospital revenue will be calculated using data for the hospital alone, from audited financial reports filed with the Maine Health Data Organization in accordance with that Agency's rules. In the event that financial statements are not timely filed with the Agency, data will be taken from the hospital's Medicare cost reports.
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> Adjustments for differences in average cost per discharge (subparagraph 3(A)(2)(b)) will be made using information from *The Almanac of Hospital Financial and Operating Indicators,* which is published by Ingenix on an annual basis. We have chosen this data source because of the robust nature of the database used by Ingenix. This database relies on data taken from 3,000 of the nation's hospitals and is the largest such public database in the country.

The revised rule also includes an adjustment for differences between Maine and New England with regard to the median cost per Ambulatory Patient Classifications – APCs – which are units of outpatient activity. The data source that will be used for this calculation will be custom reports prepared annually by Cleverley & Associates of Ohio at the request of this Office. Cleverley & Associates is a well-known and well respected consulting firm that does a great deal of work for the hospital industry. The Office will post a copy of the report on its website to provide public access to the information.

In paragraph 3(A)(4), the rate of growth in per capita income will be calculated using Maine data published annually by the Bureau of Economic Analysis, US Department of Commerce. The rate of growth in per capita health care expenditures will be calculated using Maine data published annually by the Office of the Actuary, Centers for Medicare and Medicaid Services, US Department of Health and Human Services, trended using the national projections of rates of growth specific to each cost component, used by the Office of the Actuary in the development of projections for the National Health Expenditure Accounts.

Comment: We received a number of comments questioning the policy rationale for the series of adjustments made in the rule to basis for the Fund value. One commenter stated that it appeared that the intent of these adjustments as drafted is to ensure a downward adjustment to the historical level of hospital spending. [Commenters 1, 2,14,15,18]

Response: While some of the commenters suggested that the rationale for the process selected be somehow incorporated into the rule itself, we believe the language of the rule should be restricted to describing the process for establishing the value of the CIF only. Instead, we describe the policy basis for the design of that process in this document.

Our objective in crafting this proposed rule was to construct a reasonable, straightforward strategy to sizing the Fund at a level that recognizes the limits of our economic resources as well as the benefits CON investments can bring to the orderly and rational development of Maine's health care system. The proposed rule represents the first time the Governor's Office will engage in rulemaking for the purposes of establishing an annual Capital Investment Fund limit. During the mid-1980s and early 1990s, the Maine Health Care Finance Commission did administer the Hospital Development Account, which functioned to limit CON awards to hospitals in any given year. However, the Hospital Development Account operated within the context of a comprehensive hospital rate regulation program and provides us with little relevant guidance for the directive provided by the new statute. We were therefore left with the challenge of developing a new approach appropriate to today's environment, constraints and considerations. In approaching this challenge, we considered factors that may contribute to the need for capital investment, crafting adjustments to historical investment levels to ensure the level of the CIF is appropriate. These factors considered are described below. Importantly, not all of these considerations resulted in an explicit adjustment. The rationale behind those decisions are described below, as well.

Age of Plant – We reviewed data on the age of the physical plant of health care facilities in Maine. The data available to us on this topic are restricted to hospitals; no comparable data (in the public domain) are available for the health care system as a whole. Average age of plant indicates the relative age, in years, of hospitals' fixed assets – bricks and mortar. A lower average age implies a newer fixed asset base and a lesser need for replacement in the near term.

According to *The 2004 Almanac of Hospital Financial & Operating Indicators*[1] (Ingenix, 2004), the average age of plant in Maine in 2002 was 9.85 years, as shown in the Table 1, below. Of 43 states for which data are available, Maine ranks 20th in terms of average age of plant, with most states having older facilities. In the northeast, all states but New Hampshire have older physical plants than Maine. This suggests that the condition of capital in this state tracks that of the nation and is, on balance, similar to that found in our neighboring states, the exception being New Hampshire, which has tracked far below the regional and national averages for several years. Age of plant in Maine is also comparable to the age of plant of Canadian hospitals. In New Brunswick, the age of plant has averaged approximately 10.5 years over the course of 1999-2002; for all Canadian hospitals (with the exception of PEI and Quebec facilities, for which data are not available), age of plant averaged about 9.5 years over the same time period.[2] These data indicate that Maine is on par with the rest of the nation and – with the exception of New Hampshire – with our neighboring states, in terms of investment of resources in capital projects.

Table 1: Comparison of Average Age of Plant

State	Avg Age of Plant, 1998	Avg Age of Plant, 1999	Avg Age of Plant, 2000	Avg Age of Plant, 2001	Avg Age of Plant, 2002
Maine	8.68	9.50	9.71	9.77	9.85
New Hampshire	9.25	7.55	8.28	8.21	7.89
Vermont	8.75	8.92	9.62	9.73	9.92
Massachusetts	10.34	10.34	9.6	9.58	9.67
Connecticut	9.02	9.49	9.49	10.54	10.22
New Jersey	9.66	9.63	9.99	10.59	11.01
New York	10.99	19.48	10.16	11.62	11.79
Pennsylvania	10.30	10.48	10.40	10.88	11.50
Rhode Island	10.93	9.12	9.91	10.33	11.47
Northeast[3]	9.85	9.95	9.82	10.18	10.83
Rural Hospitals	9.45	9.45	9.71	9.87	9.98
All	9.26	9.22	9.39	9.56	9.77

The Ingenix data cited above is derived from a robust data base of 3,000 US hospitals. Other data bases with similar benchmarks draw data from substantially smaller pools. Moody's, for example, uses a pool of less than 400 hospitals all of which have more than 4000 discharges each year. In 2002, only 11 Maine hospitals met that threshold, a group comprising the state's larger facilities.

[1] *The 2004 Almanac of Hospital Financial & Operating Indicators*. Ingenix, Inc. 2003.
[2] Canadian Institute for Health Information. *Canadian MIS Database: Hospital Performance Indicators 1999-2000 to 2001-2002.* May 2004.
[3] Northeast includes ME, NH, VT, MA, NY, NJ, RI, CT and PA

Technology – The statute directs us to consider technological developments and the dissemination of technology in health care as we consider the sizing of the CIF. It is interesting to note that subsequent to the imposition of the CON limitations on the acceptance of Letters of Intent by the Department of Health and Human Services, implemented in May 2003, many projects involving expensive technology such as MRIs exhibited a decline in associated capital expenditures; that is, the "price" of the equipment appeared to fall. Projects that would have otherwise been subjected to review under the CON regulations because of the expenditure trigger were able to proceed in spite of the limitation because the cost of the technology had continued to decline.[4] This phenomenon suggests that there may be decreased pressure on the CIF due to declining costs of technology as it becomes increasingly disseminated into everyday practice. Similarly, we know of no new technological developments that are likely to be disseminated in the near term (the period covered by the first CIF), thus negating the need to set the level of the CIF higher than it might otherwise be if one just considered historical trends in CON approvals.

Other factors – The Almanac provides several other interesting benchmarks for consideration. One such measure is the dollar value of capital costs per discharge, adjusted for differences in wage rates and case mix. Available data indicate the gap between Maine's capital cost per adjusted discharge and that of New Hampshire has been narrowing. While there are no data available for Vermont, Maine has consistently outpaced Massachusetts in this measure, as it has the northeastern region and rural hospitals, generally. While capital costs per adjusted discharge for the nation as a whole is steady, Maine has caught up ($452.25 in 2001) and has now surpassed the national performance standard ($423.28 in 2001).

Another measure available is the rate of growth in capital expenditures, which reflects the addition of capital assets (property, plant and equipment) that is added in a single year; a higher "score" in this measure indicates a more active program of capital investment in additions and replacement of facilities.

Data for Maine and benchmarks is shown below in Table 2. With the exception of New Hampshire and Rhode Island, Maine hospitals lead other New England states, the Northeast, rural hospitals and the US with regard to this measure.[5] This implies that we are investing in hospital capital at a faster rate than is generally observed in the benchmark areas.

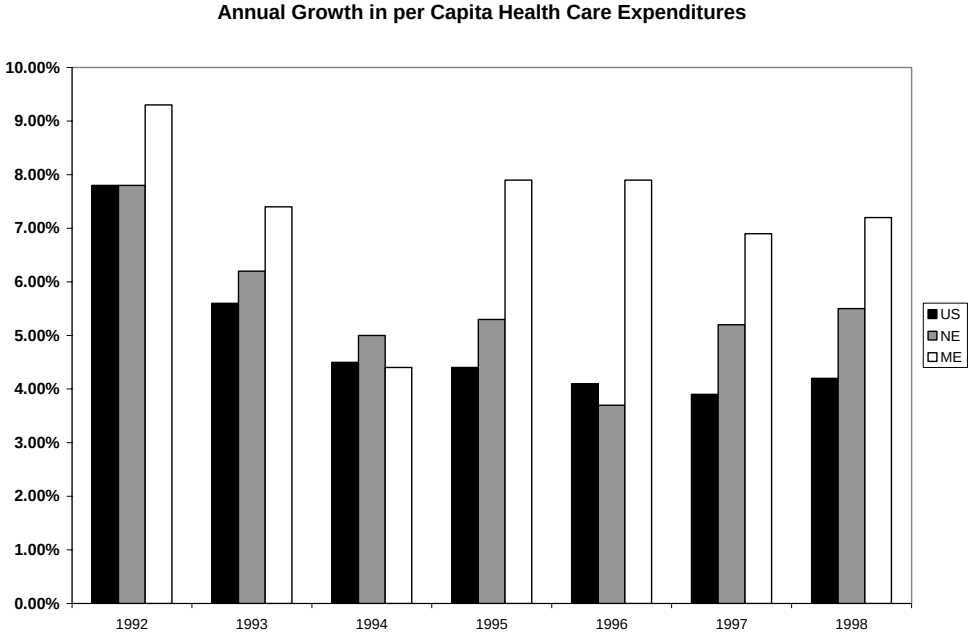
After reviewing these data, we find little persuasive evidence that we should accelerate our rate of investment in facilities at the present time, although there will almost certainly be instances where renovation, replacement and, in some circumstances, new construction might be required and/or desirable. In fact, because Maine's overall health care costs are high relative to other parts of the nation, the argument may be made that we should slow our rate of capital investment and/or focus investment in projects that result in a decrease in operating costs.

[4] Personal communication with Wm. Perfetto, Director, Maine Certificate of Need Program, DHS.
[5] *op cit* at 1.

Table 2: Capital Expenditure Growth Rates

State	Capital Expenditure Growth Rate 1998	Capital Expenditure Growth Rate 1999	Capital Expenditure Growth Rate 2000	Capital Expenditure Growth Rate 2001	Capital Expenditure Growth Rate 2002
Maine	7.5	8.4	11.0	8.0	6.9
New Hampshire	8.3	8.6	5.3	8.8	7.3
Vermont	7.9	6.7	6.0	6.3	6.5
Massachusetts	6.2	6.0	5.5	4.7	6.3
Connecticut	8.9	6.3	4.3	3.8	4.6
New Jersey	6.1	6.1	4.0	4.7	5.3
New York	6.5	6.2	4.7	3.9	4.4
Pennsylvania	5.9	5.8	5.7	4.9	6.0
Rhode Island	4.9	6.9	6.7	5.8	9.9
Northeast	6.3	6.4	5.5	5.5	5.5
Rural Hospitals	6.6	6.6	6.1	6.1	5.7
All	7.0	7.1	6.4	6.3	6.2

Maine's growth in per capita health care expenditures between 1991 and 1998 (the latest year for which state specific data are available) was over 7%, exceeding that of any other New England state or for the US as a whole.[6] (See chart below.) In 1998, Maine's annual growth rate was approximately 7.25%, compared to 5.5% in northern New England[7] and 4.25% nationwide. Clearly, Maine's spending on health care is accelerating at a rate that far outpaces our region and our nation.



Income – Importantly, Maine's household income lags behind the rest of New England. According to the US Census Bureau, the 3-year average median household income in

[6] Source: http://www.cms.hhs.gov/statistics/nhe/state-estimates-residence/us-per-capita10.asp
[7] Northern New England includes ME, NH, VT, MA, CT, and RI

Maine for 2000-2002 was $37,654 and ranking 43rd in the nation.[8] This compares the New Hampshire's median income for the same time period of $53,546, Massachusetts' figure of $50,587 and Vermont's of $41,929. In 2002, the US median household income level was $42,400, more than 12.5% above Maine's 3-year average.

The implication of these data is that Maine residents have less ability to support high health care costs than do neighboring states or the country taken as a whole. At the same time, our per capita health care expenditures are climbing at a rate faster than that observed nationally, yet our health status is not showing improvement proportional to that investment. More spending does not necessarily translate into improved health: despite Maine's high level of spending, Maine has high rates of preventable disease. More Mainers smoke, more have and are at risk for heart disease and stroke and more of our citizens have diabetes than in all other New England states.[9] And, while our cancer rates are not the highest, more people die of cancer here than in the rest of New England.[10]

Poverty does correlate with poor health and might suggest that Maine should spend more – not less – on health care. But the Dirigo reform initiative makes clear that spending should increase for access to care, prevention, primary care and treatment of chronic illness, funded in part by redirecting spending away from capital and bad debt/charity care. Such a shift in our patterns of spending serves to lower the cost of care overtime. Investment in an already sound capital infrastructure under such unfavorable economic circumstances would seem ill advised and inflationary. As noted earlier, the data indicate our capital infrastructure in Maine is, on the whole, sound and tracking or outperforming the rest of the Northeast and the US, which can be interpreted as evidence that, instead of maintaining our current levels of capital investment, we should be reducing them.

It is important to recognize that applying such a downward adjustment does mean that Maine will be investing fewer resources in significant projects than we likely otherwise would or have historically. The result of this will be an increasing age of plant, declining rate of capital investment, etc. Some might argue that this outcome is highly undesirable and to be avoided at all cost. As the data presented above indicate, we cannot sustain the current level of expenditure and investment. Given our relatively favorable position with regard to the capital structure of major portions of our delivery system, we believe curtailing spending in the manner contemplated here will not result in undue adverse consequences to the quality of health care provided in Maine. Indeed, careful planning will also assure strategic investment in Maine's health care system over time, prioritizing the type of capital expenditures that are most needed as well as to assure that age of plant and necessary upgrading of facilities are considered.

It is entirely conceivable that at some point in the future, the indicators discussed here will change. Shifts in Maine's position relative to benchmarks may just as easily result in

[8] Source: US Census Bureau, Current Population Survey, 2001, 2002, and 2003 Annual social and Economic Supplements as reported at http://www.census.gov/hhes/income/income02/statemhi.html, May 3, 2004.
[9] Kaiser Family Foundation, State Health Facts Online, www.statehealthfacts.kff.org; and National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, Center for Disease Control. www.cdc.org.
[10] American Cancer Society, *Cancer Facts and Figures 2004*. www.cancer.org.

the application of an upward adjustment to the CIF. This ensures that Maine's performance is tracking that of the relevant benchmarks, without causing harm to our health care system or our citizens.

Comment: Several parties commented on the manner in which the proposed rule contemplates the use of an *ad hoc* panel of experts to advise the Governor's Office regarding the adequacy of the value of the Capital Investment Fund. Some noted this sets up a rather open-ended process that is susceptible to influences outside the formulaic approach set forth in the early sections of the proposed rule to arrive at an initial value for the Fund. Commenter 1 stated that leaving the process open to input from the expert panel or from the Governor's Advisory Council was contrary to the statutory intent of the enabling legislation, which categorizes the rule governing the process of establishing the CIF as a major and substantive rule. Commenter 14 suggested that the use of the expert panel as proposed is contrary to the language of the statute, which allows the "creation of an ad hoc panel" of experts to advise the Governor in establishing the value of the Fund. Other comments urged the establishment of a core membership for such an ad hoc panel, by representation of specific subject matter expertise. [Commenters 1, 3, 14]

Response*:* We have carefully considered the comments received regarding the use of an expert panel to advise us regarding the level of the Capital Investment Fund. We have concluded, however, that the proposed rule is true to the letter and intent of the enabling legislation and allows the flexibility we will need to address the wide range of issues and questions that are certain to arise over time.

The purpose of this rule is to set forth the process by which the annual value of the Capital Investment Fund will be determined. In an effort to provide a degree of predictability to this process, we chose to rely on a process that is, in large measure, formula driven. The formula is driven on historical experience and factors in the ability of the people of Maine to support additional capital investments while recognizing the influence of severity of illness and the age of our population. By working through the formula, one is able to arrive at an initial value for the Fund, which is then considered against the advice of the Governor's Advisory Council on Health Systems Development and, if required, experts in the field of health care and health systems.

No formula is able to anticipate any contingency that might present itself in the future. For instance, there may come a time when there is an appearance of new technologies so compelling that we choose to adopt them regardless of their potential to introduce new system costs in excess of the level indicated by the CIF. Alternatively, a project may be proposed that represents an extraordinary expense, but the need for which may be outweighed by its costs (this situation is alluded to in a comment submitted by Commenter 15). The statute contemplated this need by allowing the Governor's Office to call on experts to advise the process and by calling for the Advisory Council on Health Systems Development to provide input into the valuing of the Fund. These features provide a safety valve, allowing the Fund value derived from the formula to be adjusted for unforeseen circumstances.

Because we cannot accurately name the circumstances that may arise at some future point in time, we cannot specify membership – either in terms of actual persons or even simply areas of expertise – for the ad hoc panel. Such a panel must be convened at the time it is needed and must comprise the most appropriate expert voices that may be brought to the table. This level of flexibility allows us to tailor the use of experts to the issues at hand. However, we do believe it is appropriate to describe the qualities we will demand in any expert we rely on. Those qualities are now spelled out in the rule and include having knowledge of the issues of concern as demonstrated by their publication in peer reviewed journals and/or by their work or research experience. The rule continues to require that experts may not have a financial relationship with any potential applicant for approval under Maine's Certificate of Need Program, nor with any commercial or public payer who may be affected by a potential Certificate of Need proposal.

Importantly, the rule requires the value of the Fund to be made the subject of notice and public hearing for additional input. This allows all interested parties the opportunity to comment on the value and provide information for consideration in determining the final value. We believe this process results in a Fund level that is grounded in a sound methodological approach and, at the same time, recognizes the inevitability of unforeseen factors arising that must be given proper consideration. This is what we believe the statutory intent to be and therefore decline to amend the rule as suggested.

Comment: We received a number of comments pertaining to the calculation of the historical base that will be used as a starting point for valuing the CIF. The rule as proposed specifically excluded so-called "extraordinary" projects from the base. The commenters suggested that such an exclusion was arbitrary and inappropriately depresses the base value. Others commented that the exclusion of extraordinary projects from the 5-year historical "look back" was, indeed, appropriate and desirable. [Commenters 1, 2, 3, 5, 15, 18]

Upon careful consideration, we find ourselves persuaded – at least in part – by those arguing for inclusion of extraordinarily large projects in the calculation of the historical base. We had originally excluded extraordinary projects on the premise that such projects are relatively rare events and therefore should not be "allowed" to influence the size of the historical base. However, very large projects will inevitably come up for review from time to time. Therefore, it would be unfair to ignore their existence when identifying the base upon which we will move our capital investment forward into the future. However, when considered in light of the proposed method to "count" the impact of very large projects against the Capital Investment Fund as they are approved in the future, we believe that a similar approach should be applied to the calculation of the base value.

The rule as proposed called for extraordinarily large projects (those with 3rd year costs in excess of $2 million) be spread out over multiple years, with no more than $2 million for any single project "debited" against the Fund in any single year. This is meant to avoid the situation where one project monopolizes the entire Fund value for a year, obviating the ability to approve any other project. We find it sensible to include extraordinarily large projects in the base value of the Fund by taking a similar approach.

We have amended the rule to include very large projects (such as the CMMC cardiac surgery project) in the historical base, but to include no more than $2 million associated with such projects in any given year, instead spreading the project's cost over multiple years. Therefore a $10 million project would be spread over 5 years; a $4.05 million dollar project would be spread over 3 years, with $2 million in each of 2 years and $.05 million appearing in the 3rd year.

This approach fairly reflects the importance of these projects in evaluating the importance they have had in establishing our historical spending patterns, but does so in a manner that acknowledges the way we intend to move forward with recognizing extraordinarily large expenditures.

Comment: A number of commenters suggested that the proposed adjustment for differences in the median age of Maine's population from that of the nation's was unnecessary. These comments argue that such an adjustment can be considered duplicative insofar as the rule makes additional adjustment for differences in case mix. Further, one of the commenters notes that age has little impact on health care costs and so should be eliminated or substantially reduced as an adjustment to the value of the CIF. [Commenters 3, 5]

Response: Upon further research, we find we are in agreement with the arguments posed by these commenters.

The extent to which Maine's older population drives health care spending has been overstated. Maine is older than the rest of the nation; in the 2000 Census the median age in Maine was 38.6 years, whereas the nation's median age was 35.3 years. It is true that health care expenditures on behalf of an elderly person will be higher than those on behalf of a younger person; this is due primarily to the cost of care provided in the final weeks and months of a person's life, as well as the cost of nursing facility services.

However, there is significant evidence that the burden of disability – a cost driver in that it necessitates additional services – is, in fact, declining among the elderly and rising in the non-elderly population; this closing of the elderly/non-elderly disability gap in effect lessens the relatively higher per person/point in time costs of caring for elder versus younger persons.[11]

Second, there is a difference between (a) age-specific health care use and costs (i.e., comparing spending for one elderly individual and one younger individual) and (b) overall costs attributable to the aging of the population. Simply put, the aging of the population simply occurs so slowly as to result in little overall impact on total health care spending. Studies estimate that the aging of the population will perhaps contribute between 0.4% and 0.5% health care spending between 2000 and 2030 – certainly not a major driver of the rapid rise in health care costs.

[11] Reinhardt U. Does the Aging of the Population Really Drive the Demand for Health Care? *Health Affairs.* 22(6):27-39.

Importantly, the proposed rule includes an adjustment for severity of illness – which recognizes age of the patient as a factor – for both inpatient and outpatient activity (see next comment and response). To employ a discrete adjustment for age does "over-adjust" for that factor. In light of this information, we find it appropriate to eliminate the discrete age adjustment included in the proposed rule.

Comment: Some commenters noted that the proposed rule was faulty in that it recognizes only inpatient services as a component of hospital activity and ignores outpatient activity. This exclusion is significant as outpatient activity is a rapidly growing sector of business for our hospitals. [Commenters 1, 18]

Response: When proposing this rule, we were unaware of any useful measure of outpatient activity that might be used in sizing the value of the CIF. The science of describing outpatient units of service is still relatively young. Still, we recognize the shortcomings of our proposed methodology as a growing proportion of capital investment is being devoted to ambulatory services.

Since putting this chapter out for public hearing and comment, we have had the opportunity to research one particular measure of outpatient activity – Ambulatory Patient Classifications or "APCs." This approach to measurement is relatively widely known and accepted as being fair and reasonable. In an effort to be as fair as possible in setting the CIF, we engaged the services of Cleverley & Associates, a consulting firm out of Ohio, which has among its clients many, many hospitals across the US. One of Cleverley's most well known products are indices of APCs. We requested from Cleverley a custom report of APCs in Maine, the Northeast and the US, showing the median values for each.

We accept the commenters suggestion that our method of setting the value of the CIF would be more appropriate if an adjustment for outpatient activity were incorporated. We have therefore amended the rule to adjust a portion of the historical level of capital investment that is reflective of outpatient activity[12] by the difference between the median APC value for Maine and that of the nation.

Comment: One commenter noted that while it seemed appropriate to establish a "maximum that any one project could be awarded" it was difficult to know whether $2 million – the proposed limit – was the right amount. [Commenters 3, 14]

Response: It is important that we clarify that the $2 million limitation is not a maximum award for any given project. Instead, $2 million is the maximum that may be "debited" against the CIF in any single year. Therefore, a $6 million may be approved, but its value will count against the CIF at the level of $2 million over 3 years. This strategy was adopted to allow for the approval of large projects but to avoid situations where such projects monopolize the entire value of the CIF in a single year.

We chose the $2 million level based on historical data, which demonstrate a natural "break" in the value of approved projects.

[12] This portion is derived from the relative proportion of outpatient revenue to total revenue.

Comment: A commenter encouraged us to carve out certain types of costs from 3rd year operating costs. The costs in question include advertising, administrative and uncompensated care costs, among others. The commenter suggests that some of these expenses contribute to a competitive as opposed to collaborative health care environment and may lead to inappropriate recognition of administrative costs. [Commenter 5]

Response: While we appreciate the view expressed by this commenter, it is not clear to us how such adjustments might be made with the data available to us. We believe that the suggested adjustments would require new, primary data collection efforts that would be difficult to carry out and result in data that are difficult to verify. Given the variations in accounting methods used across hospitals, such a task would be challenging and costly to carry out. While the final valuation of the CIF might be marginally better as a result, the costs of incorporating this effort outweigh the potential benefit. We therefore decline to amend the rule as suggested.

Comment: One comment received suggested that the term "interested parties" used in the proposed rule be specifically defined to include "any member of the public or an organization representing the interests of consumers…concerned with the affordability, availability or quality of health care services in Maine." [Commenter 5]

Response: The term "interested parties" is a common one and is intended to include any person or organization considered a stakeholder in a public process. The public notice and hearing process set forth in the rule is intended to elicit the participation of the spectrum of persons and organizations impacted by the Capital Investment Fund. The rule clearly lays out the guidelines the Office must follow in terms of giving notice and opportunity to comment. While not officially a process governed by the Maine as does the APA. Therefore, we do not believe it necessary to include a specific reference to consumer interests in the rule and therefore decline to make the amendment suggested.

Comment: We received comments regarding the rule's use of third year capital *and* operating costs. The commenters argue that operating costs include capital costs and, therefore, our use of both terms may result in a double-counting of capital expenses. [Commenters 5, 15]

Response: The definitions section of the rule clearly defines both capital costs and operating costs. Operating costs are defined to be exclusive of capital costs. We find the rule to be clear as proposed and do not believe that the double counting feared by the commenter will occur.

Comment: We received several comments regarding the fact that the proposed rule does not establish a specific value for the Capital Investment Fund, just the process by which that value will be calculated. These commenters suggest that failing to set the value by rule is contrary to the statute and in violation of the Maine Administrative Procedures Act. [Commenters 1, 2]

Response: 2 MRSA chapter 5, §102 governs the Capital Investment Fund. Subsection 2 of that provision specifically states that "[T]he process for determining the capital investment fund amount must be set forth in rules…" Language directing the Governor's Office to go to rulemaking appears nowhere else in the statutory language pertaining to the Fund except for §105, which deems rules adopted pursuant to the chapter are major and substantive rules. There is no language in the statute that requires the *amount* of the Fund to be set forth in rule.

The rule we have proposed establishes a detailed process for arriving at a value for the Fund. Once that value is determined, it is subject to input and advice from the Governor's Advisory Council on Health Systems Development which is statutorily obligated to provide input on such issues and charged with conducting hearings on the Fund value each biennium, as well as subject matter experts as needed and appropriate. The rule also requires the Governor's Office to give public notice regarding the value of the Fund, conduct a hearing to gain public input and solicit comments on the adequacy of the value. While we do not believe the statute requires us to set the value of the Fund each year by rule, we have chosen to engage in a process that is similar to that required by the Administrative Procedures Act; timelines for notice, hearing and comment have been amended to mirror that of the APA. This choice was made specifically and deliberately to ensure public participation in the process.

The proposed rule is, by statute, deemed major and substantive. Once it is provisionally adopted, it will have to be submitted to the Legislature for review and approval. This gives legislators and stakeholders another opportunity to provide input that can help shape the process to be used to determine the value of the CIF. This fact, taken in conjunction with the opportunities for public participation in the process safeguards the public's interest. We disagree with the suggestion of these commenters that this approach is contrary to the enabling statute or the APA – either in spirit or letter of the law.

Comment: Comments were submitted pertaining to the adjustment made for differences between the average cost per discharge in Maine and that of the US, generally. These comments suggested that benchmarking Maine against the Northeastern region is more appropriate, as most Maine citizens who seek care outside of the state receive it in the northeast. [Commenter 5]

Response: Discharge data show that, on an annual basis, approximately 5,500 Mainers seek inpatient care outside the state; of these 3,000 are discharged from Boston hospitals and the balance from hospitals in New Hampshire,[13] indicating that most Maine residents receiving care outside the state are, in fact, receiving care in the northeast. For this reason, we concur that the more relevant and appropriate benchmark for this adjustment is the northeast as opposed to the nation. Similarly, we will use a regional benchmark for adjustments arising from differences between the median cost per unit of outpatient activity – or APC. We have modified the rule accordingly.

[13] Personal communication with Eugene Stanton, Maine Health Data Organization. July 26, 2004.

Comment: We received a number of comments regarding the advisability of factoring CON projects "in the pipeline" into the calculation of the CIF value. Some commenters urged us to account for the fact that there had been a one-year limitation on the filing of CON applications, generating a backlog of projects to be reviewed during the first year under the Capital Investment Fund. Others stated that the rule appropriately does not provide an adjustment to accommodate the large number of projects now being proposed for review. [Commenters 1, 5, 15, 18]

Response: The one year limitation on the review of CON projects was implemented on May 5, 2003 by Governor Baldacci. Noting that "we want the best, not the most, health care," the Governor cited the need for a cooling off period in terms of health care cost drivers, while we worked to develop a coherent state health plan to map the path of our health care system and to develop stronger controls over CON and major capital investments. This effort was launched as a response to the rapid rise in health care costs we have experienced in this state, leading to an untenable and unsustainable level of spending.

The high number of Letters of Intent ($200+ million) submitted may, in fact, be attributable to "pent up demand" within the hospital industry, as the one-year CON limitation precluded the submission of proposals. However, the dollar values reflected in the filed Letters are already considerably higher as well. In 1998, the CON Unit approved $81 million in capital costs. This figure dropped during the period 1999-2001, with approved capital costs totaling $46 million in 1999, $41 million in 2000 and $49 million in 2001. In 2002, $100 million in capital costs were approved.[14] The cost estimates included in the currently filed Letters of Intent (more than $200 million) are well above that most recent level, *indicating the potential for extraordinarily high costs being infused into our health care system.*

It is important to note that costs associated with Certificate of Need projects represent only a fraction of the total investments made by health care providers.[15] For example, in 2002, CON projects represented only 20% of total capital expenditures made by hospitals, the balance of investments falling outside the purview of the CON program. It is reasonable to estimate, then, that the total value of capital investment currently "in the pipeline" is $1.07 billion[16] for both projects reviewable under Maine's Certificate of Need program as well as projects that do not require such review.

Clearly, we continue to face a crisis in terms of health care spending. We must continue to exercise discretion and restraint in our spending, bearing in mind that the process established by the rule includes a mechanism to allow for extraordinary projects, even if they are not able to be accommodated within the CIF value calculated via the formula. We believe that the process established in the rule for sizing the amount of the CIF is appropriate and fair, despite the number and size of projects contemplated in the filed Letters of Intent, and respectfully decline to adjust the rule as proposed.

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[14] *ibid*

[15] Nancy Kane, DBA. Maine Hospital Financial Performance: 1993-2002. Presentation to Commission to Study Maine's Community Hospitals, June 21, 2004.

[16] ($214 million/20%)

Comment: One commenter took exception to the data used to support our policy position that age of plant in Maine is excessive. This commenter suggested that instead of relying on data provided by Ingenix, we should, instead, consider alternative resources from which a national benchmark may be derived such as Moody's, Standard & Poors, and Fitch. The commenter noted that these resources show Maine's hospital age of plant to be older than the national benchmarks noted in these alternative publications. [Commenter 18]

Response: We were unable to access data from the proprietary databases referenced by this commenter. Upon request, the commenter provided us with documentation supporting the information conveyed in his remarks. He obtained the data through his membership in the HFMA, or Healthcare Financial Management Association; it is not publicly available. Interestingly, these data are from organizations that are engaged in the business of rating organizations for public financing.

In researching this information, we learned from a representative of Moody's that each of the median values it calculates – including age of plant – are derived from a relatively small survey (N=500) of hospitals across the country. Moreover, the hospitals surveyed are generally larger institutions with 100 beds or more and more than 4,000 discharges annually. This makes sense given the business of these organizations, which is to rate risk for potential purchasers of bonds to underwrite the costs of major projects. Moody's uses a subset of this hospital survey population to compute age of plant. In all, 343 hospitals and health care systems are examined for purposes of calculating average age of plant. While similar contacts were not made to Fitch or Standard & Poors, it is our understanding that those organizations take a like approach to developing their statistics.

In contrast, the Ingenix data are gathered through a survey of 3,000 hospitals across the country, populating a database that is the largest of its kind. There are approximately 5,000 community hospitals in the country. Clearly, the Ingenix database is much more robust than that of the rating agencies cited by the commenter and therefore a preferable source of data to be used for benchmarking. Further, while the rating agency's statistics do show a relatively "older" age of plant in Maine than that of the nation, the differences are fairly slight, with the greatest difference being between Maine and the Moody's rating at 6/10ths of one year. We therefore find that our conclusion regarding age of plant as being at an appropriate level in Maine is sound and decline to adjust the rule as suggested.

Comment: A commenter suggested that while Maine's cost per case mix and wage adjusted discharge is higher than the national average, the difference is attributable to higher staffing ratios in Maine. He notes that higher staffing ratios are correlated with better outcomes of care and patient satisfaction. While not explicitly suggesting that the adjustment proposed in the rule be altered, we assume that this commenter was asking to reconsider making an adjustment for differences in this statistic between Maine and the rest of the nation. A second commenter noted that monies within the health care system need to be redirected away from capital investment and into patient care, as reflected in higher nurse staffing ratios. [Commenters 13, 18]

Response: The historic rate of increase in Maine's health care costs has been rapid. Insofar as the CIF was enacted in an effort to help stem the rate of growth in those costs, it is also reasonable to reflect in the determination of the Fund level an adjustment to reflect the fact that Maine's cost per discharge is substantially higher than either the US average or the New England average. This will assist the effort to bring our spending in Maine more in line with that occurring elsewhere in the country.

The discounting we are using in this instance is based on the difference between the Maine and US/northeast region average values for total cost per case mix and wage adjusted discharge, reflecting outpatient activity, over the five year historic reference period. The data used to determine that difference are taken from the Medicare Cost Report values as published in the *2004 Almanac of Hospital Financial and Operating Indicators* (Ingenix, 2004). Our decision to rely on operating cost values as opposed to just capital cost values relates to our use of a historical average CON award figure that reflects both capital and non-capital costs.[17]

Maine averaged 17% higher than the national average cost per adjusted discharge and 24% higher than the northeast region. As discussed earlier in this document, we have chosen to amend the rule as proposed to benchmark Maine's performance against that of the northeast, as opposed to the US as a whole.

The Ingenix data included in *The Almanac of Hospital Financial and Operating Indicators* supports the commenter's statement. Maine does, in fact, have a higher ratio of full time equivalent personnel per occupied bed (adjusted for differences in case mix) than does any state in the northeast with the exception of New Hampshire, or of the country as a whole.

While this statistic may indicate absolute higher staffing ratios, it may also be attributable to other factors. For example, Maine's occupancy rates tend to be lower than that of hospitals in the northeast, rural hospitals or all US hospitals. This is likely associated with the fact that smaller hospitals generally have lower occupancy rates (and appropriately so). Maine hospitals also have higher occupancy rates per staffed hospital bed (as opposed to rates per licensed bed, as many licensed beds in hospitals are "closed" and not staffed because they are not needed at the present time). Length of stay in Maine is longer than that observed in the northeast, rural hospitals or all hospitals across the country.

This mixture of statistics presents a somewhat confusing picture of the efficiency of Maine hospitals. First, as length of stay declines, the staffing ratio per occupied bed goes up because of the compression of service intensity – which is loaded into the first days of an inpatient stay – into fewer days. Yet Maine's average length of stay is higher than the benchmarks. This may be due, in large measure, to the sizes of our hospitals, many of which are very small. These facilities may be staffed up to a higher level than peer facilities, resulting in poorer performance in terms of efficiency.

[17] Capital costs per case mix and wage adjusted discharges are approximately 5% higher in Maine than in the US and 12% higher than in the northeast region.

Maine led its peers in terms of supply costs per case mix and wage adjusted discharges in 2001.[18] In terms of compensation costs (which reflects inpatient person-hours per discharge, salary per full time equivalent and employee benefits), Maine was substantially higher than hospitals across the northeast, rural hospitals and all hospitals, generally. Similarly, capital costs per discharge adjusted for case mix and wages are also higher in Maine. So while staffing ratios are, in fact, high, there are a variety of factors that contribute to our higher cost per discharge as well.

The Maine Quality Forum has been directed by the Legislature to conduct a study of nurse staffing ratios in Maine; a report on that study is due out during the next legislative session. The information found from that study will be instructive to us as we monitor the continued appropriateness of the process for valuing the CIF reflected in the rule. If further information becomes available that convinces us that the adjustment contained in the rule for differences in cost per discharge is inappropriate, we will not hesitate to propose amendments.

Comment: One commenter requested clarification of the rationale for increasing the hospital portion calculated for the CIF to establish the non-hospital component of the Fund, rather than simply setting aside 12.5% of the hospital component for other, non-hospital projects. [Commenter 3]

Response: The statute at 2 MRSA c.5 §102 (2) and (3), specifies that a portion of the CIF must be established for non-hospital projects and, in the first three years of implementation, that at least 12.5% of the CIF shall be set aside for non-hospital projects.

The data available to formulate the historical base for valuing the Fund is derived from hospital projects only. Because data are not similarly available for non-hospital projects, it is inappropriate to simply segment a portion of hospital spending for non-hospital projects. Instead, we have chosen to “gross up” the hospital Fund component to establish the non-hospital “sub-fund.” While this approach results in a Fund level that is higher than that which would be computed using the method suggested by the commenter, we believe the approach reflected in the rule represents a more appropriate and equitable solution. We therefore decline to modify the rule in response to this commenter’s suggestion.

Comment: One commenter suggested a number of editorial changes to the rule, such as correcting the order of definitions and the manner in which portions of the rule were numbered. Another commenter pointed out a technical problem with the method used to trend historical expenditures for inflation. [Commenters 15, 18]

Response: We thank the commenters for pointing out these errors to us and have amended the rule as appropriate. We have not, however, altered the rule to change the definition of “annual effective period” as recommended by the commenter. We believe the definition as proposed is correct because it anticipates that the annual effective period may commence on a date other than July 1st.

[18] *The 2003 Almanac of Hospital Financial & Operating Indicators*. Ingenix, Inc. 2002

Comment: We received several comments regarding the rule's provision for a carry-forward of any allowance remaining in any portion of the CIF after approval of all relevant CON projects for the annual effective period has been completed. Commenters suggested that any remaining funds should lapse and, in the absence of such a change, only a portion of any remaining funds be carried forward. [Commenters 5, 15]

Response: These commenters have presented persuasive arguments as to why the rule as proposed – which contemplated a carry forward of any remaining funds – is inappropriate. These commenters represent the consumer and business communities. Both noted that the proposed roll over of remaining funds serves to increase the level of the Fund, allowing it to grow without regard to the need for additional expenditures or the appropriateness of such expenditures during a future annual effective period. This results in a diminution of the Fund's utility as a cost containment mechanism and moves it a step away from the other considerations outlined in the rule for sizing the Fund and the considerations delineated in the State Health Plan. For these reasons, we have accepted the suggestion of these commenters and have amended the rule to cause any funds remaining in the CIF to lapse at the end of the annual effective period.

Comment: One commenter requested that we clarify how the proposed rule impacts long term care facilities. [Commenter 17]

Response: Long term care facilities are not explicitly excluded from the Capital Investment Fund by statute. However, because projects undertaken by nursing facilities are required by statute to be budget neutral (for example, a facility may not add beds if there is not a complementary decline in long term care beds elsewhere), the implementation of the Fund should exercise no impact on these facilities.

Comment: A number of commenters expressed support for the establishment of the Capital Investment Fund, citing it as an important tool in the effort to contain health care costs and in promoting the orderly development of our health care system. These commenters noted that, as a major and substantive rule, final adoption and implementation of the rule would likely be one year away. They stated that the rate at which we are currently spending on health care is extremely difficult to sustain and the prospect of allowing another year to pass without exercising the restraints on investment represented by the CIF would be extremely harmful. They urged this Office to adopt the rule on an emergency basis.

Other commenters opposed the call for emergency rulemaking, stating that to do so would be a frustration of legislative intent. [Commenters 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 16]

Response: The Governor's Office of Health Policy and Finance has carefully considered the views of these as part of a broader examination of the question of proceeding to emergency rulemaking. We have determined that immediate adoption of this rule is necessary to avoid an immediate threat to the public health, safety and general welfare of the people of Maine and have moved to adopt chapter 101 on an emergency basis. The rationale for this decision is outlined in the Basis Statement for

that rulemaking, which is a separate proceeding; the Basis Statement is posted on our website (www.healthpolicy.maine.gov) and is available upon request.

Comment: One commenter raised concerns regarding the thresholds for Certificate of Need review as well as the overall structure of the CON program. Other commenters suggested that a strong link should be made between the State Health Plan, the CIF and the CON program. Similarly, one commenter suggested that the CON process should require a higher degree of accountability on the part of applicants to implement approved projects in accordance with the specifications of the CON award. [Commenters 4, 7, 17]

Response: While we appreciate these comments, the issue of the thresholds for CON review is a statutory issue which must be considered by the Legislature; we have no authority to change those thresholds nor are they germane to this proceeding. Similarly, the Department of Health and Human Services administers the Certificate of Need program and is responsible for the development and implementation of the rules governing that process. We understand that amendments to those rules will be proposed in the near future; suggestions for modifying the review process are more appropriately directed at DHHS during that rulemaking.

We agree that there should be strong links between the State Health Plan, the CIF and the CON program. The Plan makes those links clear and the rule cites the State Health Plan as a reference point for judging the appropriateness of the Fund's value. We believe we have constructed the Plan and the rule to fairly reflect our concern for maintaining that linkage.